KANSAS
DIVISION OF HEALTH POLICY AND FINANCE
ROBERT M. DAY, DIRECTOR KATHLEEN SEBELIUS, GOVERNOR

Testimony on:
Update on Medicaid Transition

presented to:
Senate Committee on Health Care Strategies

by:
Scott Brunner
Division of Health Policy and Finance

January 31, 2006

For additional information contact:
Luke Thompson
Division of Health Policy and Finance

Landon State Office Building
900 SW Jackson Street, Suite 900
Topeka, KS 66612
Phone: 785-296-3512
Fax: 785-296-3468

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Update on Medicaid Transition

Madame Chair and members of the Committee, my name is Scott Brunner and I am the Director of Medical Policy and Medicaid for the Division of Health Policy and Finance. I would like to share with you a status report on the transition of the Medicaid program from the Department of Social and Rehabilitation Services (SRS) to the Division of Health Policy and Finance (DHPF). I would like to break my report into four main topics: moving the authority for the Medicaid program, moving of funds between the two agencies, moving people from SRS to DHPF, and finally items that still need to be completed.

Moving Medicaid

Federal Actions. On June 16, 2005, we submitted State Plan Amendment (SPA) 05-04 to the Centers for Medicare and Medicaid Services to officially transfer the single state Medicaid agency designation from SRS to DHPF. This was necessary to transfer the legal authority for Medicaid under Title XIX of the Social Security Act from the Secretary of SRS to the Director of DHPF as specified in House Substitute for SB 272. This state plan amendment required a certification from the Attorney General that the designated state agency has legal authority to administer or supervise the administration of the state Medicaid plan and make rules and regulations for administering the plan or that bind local agencies to administer the plan. CMS requested some clarifications on the SPA and the authorizing legislation, but we never received formal questions. The SPA was approved on August 9, 2005. We also submitted a change in our State Children's Health Insurance Program state plan to CMS on July 29, and that plan amendment was approved on October 17, 2005

Other administrative activities related to moving the operation of the Medicaid program included authorizing DHPF to draw federal funds and submit the quarterly expenditure reports and estimates. The authority to draw federal funds could not be transitioned until the SPA was approved. DHPF began drawing federal Medicaid funds on October 1, 2005. Since that time DHPF has made regular withdrawals from the federal Medicaid accounts and transferred federal funds among the agencies that use Medicaid funds. The staff person from SRS that was primarily responsible for assembling the quarterly reports transferred to DHPF on July 1, and continued her duties for the reports submitted at the end of August.

With the State Plan change approved, our next step has been to develop a cost allocation plan (CAP) to allow DHPF to claim federal funds for administrative costs. The CAP for DHPF was submitted on September 2, with a retroactive effective date to July 1, 2005. The CAP describes the direct and indirect costs for DHPF to administer the Medicaid program. It is based on the cost allocation formula used by SRS with the addition of the new staff that transferred to DHPF

and the Governor's Office of Health Policy and Finance. We have answered one round of questions about the methodology we proposed, and just received this week some clarifying questions. We continue to be optimistic that the CAP will be approved quickly to avoid a disruption in federal funding for DHPF operating expenditures.

Interagency Agreement. During this same period, my staff drafted an interagency agreement to describe the relationship between DHPF and SRS for cooperative administration of Medicaid services as described in House Substitute for SB 272. This agreement used the work of several SRS workgroups that were established during the development of the Governor's Executive Reorganization Order. The agreement outlines the programs each agency retains policy authority for, which agency is responsible for drawing and maintaining accountability for federal funds, continuity of privacy and security policies related to the Health Insurance Portability and Accountability Act (HIPAA), and mechanisms to resolve disputes between the agencies. There are also detailed schedules describing administrative functions provided to DHPF by SRS, the exchange of information technology and data services, and policy development and change processes for Medicaid funded services. The specific services and program assigned to each agency are shown in Table 1. This agreement was signed by Director Day and Secretary Daniels on September 12, 2005.

Transitioning provider payments. Effective July 1, 2005, the process for making provider payments through the Medicaid Management Information System (MMIS) was adjusted for the change in agencies. Staff from DHPF and SRS worked to identify services that each agency would be responsible for after the transition. This list was used to isolate procedure codes based on the agency that would fund the provider payment. The data analysis of the procedures and services paid by each agency was used to determine the amount of funding that would have to transfer from SRS to DHPF. The same analysis was the foundation for the change in the accounting system to make provider payments.

For a provider to receive a payment for Medicaid services, they submit a claim that processes through the MMIS. The MMIS processes the claim and assigns a program cost account (PCA) code to the payment amount. That information is passed to the SRS accounting subsystem, which uses the PCA to assign the expenditure to an agency and a funding source. Before July 1, MMIS expenditures were assigned to SRS, the Department on Aging, or the Juvenile Justice Authority (JJA). SRS modified its accounting system to split the MMIS expenditures between DHPF, SRS, Aging, and JJA. With all of the weekly payments split among the four agencies, a data file is sent to the Department of Administration to generate the actual payments to providers. This process allows each agency to pay for the Medicaid services it administers and account for its own Medicaid expenditures.

The majority of provider payments were made on July 1 without issue. The assignment methodology worked in both the SRS and Department of Administration accounting systems. There were a limited number of providers that did not receive payments in the first payment cycle. Some residential providers for children, primarily Level 5 facilities, were not paid because the JJA vendor file was not loaded or recognized in the Department of Administration system for Medicaid payments. Those payments were delayed by two or three days.

The other issue with provider payment was related to providers that had outstanding accounts receivable. The SRS accounting system segregated the payments among the agencies, but did not allow receivables to be satisfied across the agencies. This created a discrepancy between the payment amount generated by the MMIS and the amount of the checks that were eventually written by Department of Administration. To prevent providers from being confused by the different information from the MMIS and the payment amounts, DHPF held payments and pulled back some electronic transfers. We reissued the payments based on the MMIS paid amounts, delaying payments to providers. In the first week, approximately 50 providers were affected by this problem and there are continuing problems that impact between 10 and 15 providers each week. DHPF accounting staff reviews a weekly report of these unresolved accounts receivable and manually adjust payment amounts to account for splits among agencies.

Transitioning accounting functions. DHPF has assumed responsibility for other accounting functions, such as contractual payments, receivables, and payables. The number of staff transferred for these duties was determined based on the volume of work in SRS. We have been working to cross train the DHPF and SRS staff so that all of the accounting responsibilities can be completed. One significant gap for DHPF is staff to process and account for receivables. DHPF receives funds from 11 or more sources, including drug rebates, estate recovery payments, medical subrogation payments, premium payments, provider overpayments, and federal grant awards. No staff were transferred related to this process and staff across DHPF have been working to receive, deposit, and account for incoming funds. DHPF is able to deposit funds in our own fee fund accounts and make the appropriate credits. SRS processed part of our receivables, but we transitioned all receivables to DHPF as we moved out of the Docking State Office Building.

Moving Funds

The attached Table 2 shows the distribution of funding between SRS and DHPF starting with the FY 2006 budget submitted last September. The State General Fund amounts were divided based on the administrative functions that were moving from SRS to DHPF and the Medicaid services that were assigned to each agency. The SRS Fee Fund was divided based on the amount used to fund Regular Medical caseload expenditures. The final appropriations bill (Senate Substitute for HB 2482) transferred $40.8 million from the SRS Social Welfare Fund to the DHPF fee fund. DHPF, SRS, and the Department of Administration agreed that the transfer was not necessary as long as each agency could receive and deposit funds into its own accounts. This is true of the other transfers authorized by Senate Substitute for HB 2482. For the federal funds, DHPF will begin drawing from the total federal Medicaid award and distribute funds to agencies for claims and administrative costs.

Moving people

In all, DHPF has **140.37** authorized FTE positions. This includes 133.87 transferred from SRS, the five staff of the Governor's Office of Health Policy and Finance, and 2.5 new unclassified temporary positions funded through the Demonstration to Maintain Independence in Employment grant. Table 3 shows the position titles of the support staff transferred from SRS to DHPF that were not previously attached to Medical Policy/Medicaid.

In December, we completed moving staff from the Docking State Office Building to the 9th and 10th Floors of the Landon State Office Building. This consolidated the majority of the staff that moved from SRS to DHPF. The State Employees Benefit staff occupies the South end of the 9th floor. Medical Policy/Medicaid and the Director's office occupy the remainder of the 9th floor and the accounting, finance, federal reporting, and Ticket to Work staff occupy the North wing of the 10th floor.

What is left to do.

One of the guiding themes during the transition to DHPF has been the recognition that this is only the first step. We are trying to avoid making long lasting decisions that may have to be undone as DHPF fully merges operations with the State Employees Health Plan or as the Kansas Health Policy Authority starts meeting. There are some issues specifically related to the operation of the Medicaid program that we are addressing.

1. Modify the MMIS to support financial operations separate from SRS.

We have started MMIS policy changes to the financial and provider payment subsystem to support separate agencies. These changes are still in a design phase, but we believe that the Medicaid agency should have financial processes separate from the SRS accounting system. This also will automate and simplify some of the financial reporting mechanisms for CMS. The projected implementation date for these changes is January 2007.

2. Combine receivables into a common reporting system.

DHPF needs to develop a central receivables process to account for the multiple sources of revenue that come in through the various payment mechanisms across the DHPF. We have conducted a preliminary audit of the receivables processes throughout DHPF and it appears that the separate collection locations developed because of varying reporting and programmatic needs. The State Employees Health Plan also identified a need to improve the process for billing retirees and non-state groups that is similar to other receivables in DHPF. A central receivables system could streamline the receipting, depositing, and fund accounting needed to make sure the right funds are applied to the right bills.

3. Develop data reporting and analysis capacity.

Our primary charge as an organization is to improve the quality and efficiency of health purchasing in Kansas. Part of that mission involves using the data we have to understand what Medicaid is paying for, how much we are purchasing, and for whom. We also would like to look at the value of what we are purchasing in terms of improving the health and well being of Medicaid and SCHIP beneficiaries. We have an excellent staff of fiscal analysts and researchers, but we need to make sure they have the tools to analyze more complex questions. We also need to improve our ability to make information available to our stakeholders and customers in means that are accessible and understandable.

4. Develop budget and fiscal analysis capacity.

DHPF is responsible directly for approximately $2.0 billion in state expenditures, and provides the Medicaid oversight for an additional $500.0 million. One budget analyst

position was transferred from SRS. We have interviewed candidates for that position, and have hired a Chief Financial Officer to lead the Operations Unit including accounting, finance, and federal reporting activities. We continue to work on mechanisms to improve our ability to monitor financing issues that have long and short term impacts on the services funded with federal Medicaid dollars. This comes from reviewing expenditure trends, the amount claimed on federal reports, changes in Medicaid rules, and tracking deferrals and audit findings.

5. Support the functions of the Health Policy Authority.

To meet the statutory deadlines for making recommendations to the 2006 Legislature, the Kansas Health Policy Authority (KHPA) will need a great deal of assistance to understand the programs and services we administer. There also will be a need to provide administrative support to organize meetings, gather and respond to data requests, and develop recommendations. KHPA hired Dr. Bob Day as interim director and Dr. Andrew Allison as deputy director to provide direct support. DHPF stands ready to assist in any way possible as part of our mission to be the recognized experts on Medicaid in Kansas.

That concludes my testimony and I will stand for any questions.

Table 1

Division of Medicaid Program Responsibilities

DHPF	SRS
Medicaid - Regular Medical Services	Private ICF-MR
SCHIP	Persons with Developmental Disabilities HCBS Wavier
MediKan	Persons with Physical Disabilities HCBS Wavier
	Persons with Traumatic Brain Injuries HCBS Waiver
	Technology Dependent Children HCBS Waiver
	Public ICF-MR
	Attendant Care for Independent Living
	Targeted Case Management
	Substance Abuse Treatment
	Psychologist and Psychiatrist Services
	Behavior Management
	Community Mental Health Center Services
	Children with Severe Emotional Disturbance HCBS Waiver
	Positive Behavior Support
	State Mental Health Hospitals
	Nursing Facilities for Mental Health
	Residential Treatment Facilities for children
Family Medical Eligibility Policy	
Adult Medical Eligibility Policy	
HealthWave Clearinghouse - Eligibility Determination and Case Maintenance	Eligibility Determination for applications filed at SRS Service Centers
	Case Maintenance for Adult Medical Programs

Table 2

Status of Appropriation and Fund Transfers
FY 2006 Approved Budget

	Submitted SRS	Gov and Leg Adjs	Total	Approved SRS	Approved DHPF
State General Fund - State Operations	96,801,283	3,556,417	100,357,700	83,797,915	16,559,785
State General Fund - Medical Assistance	385,810,855	62,499,142	448,309,997	50,001,634	398,308,363
State General Fund - Children's Health Insurance	15,185,949	0	15,185,949	216,404	15,185,949
CIF - Medicaid	3,000,000	0	3,000,000	0	3,000,000
CIF - HealthWave	2,000,000	0	2,000,000	0	2,000,000
CIF - Immunization Outreach	500,000	0	500,000	0	500,000
SRS - Social Welfare Fund	65,849,741	7,554,655	73,404,396	32,614,760	
DHPF - Social Welfare Fund					40,789,636
SRS - Other State Fees Fund	no limit	no limit		no limit	
DHPF - Other State Fees Fund					187,500
Health Care Access Improvement Fund	no limit	no limit		0	44,737,733
Federal Medical Assistance	no limit	no limit		no limit	803,875,736
Other Federal Grants	no limit	no limit		no limit	536,685
Children's Health Insurance - Federal Fund	no limit	no limit		no limit	45,324,484

Table 3

FTE Staff Transfer
SRS to Division of Health Policy and Finance

Program Area	Functional Area	FTE
Management Operations	Budget *(vacancy)*	1
	Accounting	1
	Grants & contracting	1
	PERT/ IRS	3
Administration	Working Healthy/MIG Grant	2.49
Budget	Federal reporting	1
SRS Operations	Payables	4
Audits	Internal auditor	1
Economic & Employment Support	Estate recovery attorneys	2
	Estate recovery support specialists	2
	Eligibility policy	1
	Eligibility trainer *(vacancy)*	1
Personnel	Human Resources Professional	1
Legal	Attorneys	2
	Support staff	1
Information Technology	PC Support	1
	Web support *(vacancy)*	0.5
TOTAL		**25.99**